STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155199	A. BUILDING 01 B. WING	08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN 46074

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health. Survey Date: 08/01/12 Facility Number: 000106 Provider Number: 155199 AIM Number: 100266390 Surveyor: Mark Caraher, Life Safety Code Specialist At this Quality Assurance Walk-thru survey, Maple Park Village was found not in compliance with 410 IAC 16.2-3.1-19(ff). This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility does not have smoke detectors in resident sleeping rooms. The facility has a capacity of 106 and had a census of 98 at the time of this visit. The facility was found in compliance with state law in regard to sprinkler coverage and was found not in compliance with state law in regard to smoke detector	K0000	August 14, 2012 Please find the attached plan of corrections for the Survey Event ID MM1U21 performed on August 1, 2012. The provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review, in lieu of a post survey revisit. Sincerely, Zach Krumwied, HFA Executive Director Maple Park Village The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	coverage. All areas where residents have customary access were sprinklered. The facility has two detached storage buildings providing facility services which are not sprinklered. Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 08/01/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K9999	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following: (1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012. (2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012. (3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to install smoke detectors in 58 of 58 resident sleeping rooms before July 1, 2012. This deficient practice could affect 98 residents in the facility. Findings include: Based on observations with the	K9999	#1 No specific resident was identified as being affected by the deficient practice. #2 All residents have the potential to be affected by the deficient practice. Smoke detectors with a 10 year lithium battery will be installed in 58 of 58 resident rooms. #3 The Maintenance Director will perform rounds after the installation of the smoke detectors in 58 of 58 rooms to ensure function and placement is compliant. # 4To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the Smoke detector CQI audit tool weekly x 4 weeks, monthly x 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED, If threshold of 95% is not achieved an action plan will be developed to ensure compliance. #5 Compliance Date: 8.22.2012	08/22/2012

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	Maintenance Director during a tour of the facility from 11:25 a.m. to 12:45 p.m. on 08/01/12, a smoke detector was not installed in each of 58 resident sleeping rooms in the facility. Based on interview at the time of the observations, the Maintenance Director acknowledged a smoke detector was not installed in all resident sleeping rooms in the facility. 3.1-19(ff)			